

# Letters to the editor



## Dame Cicely Saunders

It was wonderful to read the articles about Dame Cicely Saunders in the recent issue of *The Pharos* (Summer 2003, pp. 4–10). I wanted to provide an additional anecdote that illustrates Dr. Saunders' generosity. During the 1982–83 academic year, I was a visiting professor at St. Thomas's hospital working on cross national issues of health care organization and financing. During that time I inquired as to whether I could visit St. Christopher's Hospice, about which I was hearing interesting stories, though I was not at that point involved in any formal hospice-type care. Dame Cicely was incredibly generous and spent a full day showing me through the center and explaining its history and how it operates.

About nine years later, when I had come to The Robert Wood Johnson Foundation, I heard the results of the SUPPORT study. Based on those dismal results, and in cooperation with leaders such as Dr. Kathleen Foley, I was able to help The Robert Wood Johnson Foundation establish a multifaceted program to improve care of the dying in the United States. Chief among our actions was to promote the use of hospice care, as well as palliative care. I like to think that Dr. Saunders' generosity helped to fuel this movement.

Steven A. Schroeder, M.D.  
(AQA, *Harvard Medical School, 1964*)  
*San Francisco, California*

## "What I Learned while Dying"

Dr. Giller's article "What I Learned while Dying" (Summer 2003, pp. 12–15) should be required reading of every medical student and every doctor!

The article gives clarity and focus to the thoughts we sense in our patients, but can't really understand or fully comprehend. It is difficult to empathize with feelings that one may not intuit or imagine; the possibility that those of us who have never been really sick could misread, misinterpret or underestimate a patient is not small.

Recently a friend's wife was diagnosed with Stage 4 recurrent breast cancer and the outlook is miserable. When I read his comments about a patient's terror, it hit me hard when thinking about her situation. That's what I was sensing when talking to her and her husband, though they would have you think it is not there. Terror, and overwhelming sadness, and grief.

Incidentally, her experience with oncologists has been terrible. I have to believe there is better language and better displays of empathy to use when handling a situation as dismal as hers, even when conveying horrifying news; this is where I think Dr. Giller's article could be helpful. If doctors better understood how it must feel from the other side, they would listen and take time and say the right things . . . or at least try to avoid harmful words and behaviors.

Kit Powers, M.D.  
(AQA, *University of Iowa, 1987*)  
*Olathe, Kansas*

## Re Antwone Fisher

I enjoyed reading Peter Dans's review of *Antwone Fisher* in the Summer 2003 issue of *The Pharos*.

I was a medical officer in the U.S. Navy from 1967–1969 and like to spot factual inconsistencies in such movies. Dr. Davenport seemed to have too many service ribbons. So, using the picture of Denzel Washington in summer khakis, which accompanied the review, I magnified the ribbons on his shirt and then identified them with a current USN service award chart. Here are Dr. Davenport's awards (from top right to bottom left):

- Meritorious Service Medal
- Joint Service Commendation Medal
- Distinguished Flying Cross
- NATO Medal (Yugoslavia)
- Navy Achievement Medal (with attachment)
- Fleet Marine Force Ribbon
- National Defense Medal
- Purple Heart (with attachment—he received more than one!)

Unidentified (looks like a Silver Star, but not a ribbon from any of the U.S. armed services)

- Expert Rifleman Medal
- Expert Pistol Medal

Dr. Davenport would probably have earned only the National Defense Medal as a junior Navy psychiatrist who (presumably) never saw combat. The ribbon is presented to all service personnel when they enter the military. Nevertheless, the ribbons Dr. Davenport wore were colorful and made him look more heroic.

I also recall that Dr. Davenport was called "Commander" during the movie. He was, in fact, a Lieutenant Commander; they are called "Doctor." This tradition is identical to that of Navy line officers, who call each other "Mister" until they reach the rank of full Commander.

Finally, I noticed that the Medical Corps insignia worn by Dr. Davenport on his collar was, in fact, the insignia of the Nurse Corps (the latter is a gold oak leaf, while the former is a gold oak leaf with a superimposed silver acorn). If you get to watch this movie again, check it out!

William Fiedelman, M.D.  
(AQA, *New York Medical College, 1965*)  
*New York, New York*

## Affirmative action: PC, M.D.

In her review of my book, *PC, M.D.—How Political Correctness Is Corrupting Medicine* (Summer 2002, pp. 57–58), Dr. Faith Fitzgerald misunderstands and misreports data on minority performance in medical school and residency, a subject I took pains to clarify. Worse, she accuses me of using data selectively.

The matter concerns the qualification of African-American and Hispanic applicants to medical schools. Data published by the Association of American Medical Colleges and elsewhere (up until 2000, when my book went to press) are consistent in the picture they paint: minority students (excluding Asians) are

admitted with significantly lower grades and MCATs, take longer to graduate, are more likely to repeat their first year, drop out and are dismissed from residency more often. When qualifications (grades and scores) are comparable to others admitted by merit, not surprisingly, minorities perform no differently from nonminority students.

To make her point, Dr. Fitzgerald uses a study by her colleagues, Robert C. Davidson and Ernest L. Lewis, at UC Davis.<sup>1</sup> Briefly, she implies that their study found that minorities had a graduation rate of 94 percent compared to 97 percent for nonminorities. That is not what this study showed. In fact, Davidson and Lewis were not able to discern the outcomes for minority students accepted via affirmative action, or, more accurately, racial preference. Specifically, they broke down their analysis into “regular admissions” (4 percent of this group were minorities) and “special consideration admissions” (53 percent of this group were minorities). A special consideration applied to standard racial preference admission as well as to nonminorities with strong leadership skills. The graduation failure rate for the special admissions group was twice that of the merit-based admissions students, 6 percent versus 3 percent.

Over the study’s 11-year period, between 10 percent and 45 percent of the class on a given year was comprised of these “special consideration admissions.” The performance of this group was inferior to that of those admitted on academic merits: far lower grades in medical school courses, lower scores on Parts I and II of the National Medical Boards. Because Davidson and Lewis did not isolate those within the special category admissions group who had been admitted through racial preferences, no conclusions can be drawn about them or their performance. It is possible, of course, that the racial preference students did well—we cannot know from the way the data were analyzed—but given the track record of students admitted via preferences, that is

not what one would predict. A number of letters to the editor of *JAMA* pointed out the limitations of the Davidson and Lewis study regarding what one can safely infer about the performance of minorities admitted under race preferences.<sup>2–4</sup> One respondent specifically and rightly questions the meaning of high medical school graduation rates in general, considering the pressures on schools to pass students along into residency.

I stand by my characterization of racial preference admissions policy in medical schools as one that—regardless of the good intention behind it—compromises standards of fairness and excellence in medical schools.

#### References

1. Davidson RC, Lewis EL. Affirmative action and other special consideration admissions at the University of California, Davis, School of Medicine. *JAMA* 1997; 278: 1153–58.
2. Zucher RS. Affirmative action and special consideration admissions to medical school. *JAMA* 1998; 279: 509.
3. Veloski J, Hojat M, Erdmann JB, Gonnella JS. Affirmative action and special consideration admissions to medical school. *JAMA* 1998; 279: 508–09.
4. Stryer DB. Affirmative action and special consideration admissions to medical school. *JAMA* 1998; 279: 508.

Sally Satel, M.D.  
*Washington, DC*

#### Dr. Fitzgerald responds to Dr. Satel

*All seems infected that th’ infected spy  
As all looks yellow to the jaundiced  
eye . . .*

—Alexander Pope

Essay on Criticism, Part ii, Line 358

Dr. Satel did indeed include in her book her awareness of the limitations of the study by Davidson and Lewis,<sup>1p189</sup> but it is disingenuous to suggest (given its citation in the chapter of her book entitled “Race and Medicine,” and surrounded by her discussion of the

perceived academic and postgraduate inadequacies of affirmative action students) that it was not intended to be a supporting reference to her contention that such students were inferior to those she calls, in her letter, “merit-based” admissions (Davidson and Lewis, in revealing contrast, termed such students “regular” admissions).

She says that the graduation failure rate for these students (6 percent) was twice that of those she labels “merit-based” (3 percent), but fails to say that the absolute number of failures, given the disproportionate size of each group (1428 “regular” and 356 “special consideration” students in 20 years) was twice as high (43) in the “regular” as in the “special consideration” (21) group: It appears that premedical grades and test scores are not infallible predictors of success or failure in medical school, which was the major point of the study. She fails also to mention that 18 of the “special consideration” students (to whom, presumably, she would have denied admission) were ultimately elected to ΑΩΑ. Most importantly, I think, she fails to mention the conclusions of the authors themselves, substantially unaltered by any subsequent criticisms of the study: “After graduation, the residency experiences of the 2 populations were quite similar, with both populations equally likely to receive honors evaluations and no detectable difference in academic difficulty in their residency training program.”<sup>2p1158</sup>

The salient point is not that some of the “special consideration students” failed, but that so many, handicapped though they were from the start by academic shortcomings, succeeded. To use selected data from this study to support the opposite conclusion seems to me to be wrong.

Alexander Pope, of course, was mistaken: people with jaundice don’t see all things as yellow . . . but we know what he means.

#### References

1. Satel S. PC, M.D.—How Political Cor-

rectness Is Corrupting Medicine. New York: Basic Books; 2000.

2. Davidson RC, Lewis EL. Affirmative action and other special consideration admissions at the University of California, Davis, School of Medicine. *JAMA* 1997; 278: 1153–58.

Faith Fitzgerald, M.D.

(ΑΩΑ, *University of California, San Francisco, 1969*)  
*Sacramento, California*

### Re “Draw the Line”

Many in society take the position that abortion is a morally acceptable solution to unwanted pregnancy. Consequently, the question of when life begins has been kept open. The tools of contemporary ethics consist of quantitation and consensus. Thus we read Dr. Mazzarelli (“Draw the Line,” Spring 2003, pp. 32–34) urging upon us the idea that the presence of brain activity as detected by electroencephalography in the fetus is the starting point of human life. Now science long ago has settled the question as to when life begins, and it is difficult to believe that anyone with any degree of scientific sophistication during their quiet and reflective moments does not know this deep in their heart.

Dr. Mazzarelli dismisses conception as the beginning of life with weak argumentation. This is an argument with a sound logical basis that deserves more vigorous disputation. The argument rests simply on the idea that each human genome is unique and has never before existed in the universe and came into existence overcoming overwhelming odds and that no power on earth has the right to destroy it. As G.K. Chesterton once said, “Every human being is a person who might not have been.” The human genome contained within the fertilized zygote is a structure of great complexity consisting of hundreds of thousands of large molecules arranged in an intricate spatial configuration. Within it is stored all of the information required to control all of the myriad characteristics of a new human individual. In a sense, it

is the person’s software. The structure is contingent on an infinite series of antecedent events that might not have occurred. Once it exists, a perilous journey remains. This nine month’s journey is full of uncertainties, but is a walk in the park compared to the journey of its constituent elements throughout the distant past.

The sperm, if left alone, is going nowhere without the ovum. The ovum, if left alone without the sperm, also is going nowhere. The fertilized zygote, however, if merely left alone, if not attacked by cures, chemicals or other noxious agents, within a few months of differentiation and growth emerges as a being that walks, talks, laughs and cries, fully prepared to enjoy a full conscious life. Potentiality to actuality. Destruction of the acorn does destroy the oak. But we are not talking here of trees, rather of human persons. No one has the right to interrupt this unfolding sequence at any stage including its very beginning which is the human genome. This truth may be inconvenient to some and may have even tragic consequences, but it is the truth. Dr. Mazzarelli has provided his answer to a question that has already been answered with logic, not quantitation, consensus or wishful thinking.

Patrick J. McCormick, M.D.

(ΑΩΑ, *University of Wisconsin, 1958*)  
*Palos Heights, Illinois*

I read with great interest the article “Draw the Line” by Anthony Mazzarelli, M.D., in the Spring 2003 edition of *The Pharos* (pp. 32–34). Being very interested in the issue, I was intrigued with his proposal to employ the same EEG criteria used for brain death to pinpoint the beginning of life. I have two comments to make.

First, I think that in his critique of the “conception rule” for establishing the beginning of life, he has oversimplified. True, conception is a point in time that is determinable, but this is not the reason it is proposed. Rather, it is the

point in time when a genetically unique, never-before-seen and never-to-be-repeated individual is constituted. This happens when one 23-chromosome sperm fuses with one 23-chromosome egg to form a 46-chromosome entity, i.e., conception. Further development will never alter this genetic individuality, only unfold it. Thus, the point cannot be moved later in life. His hypothetical proposal of a point of inevitable fertilization does not really move it to an earlier time, because it is very unlikely that at that time there would be only one sperm “in the running.” While it would (hypothetically) be certain at that time that an individual would be constituted, until one sperm “won the race” and fused its nucleus with that of the egg, it would be unknown and unknowable which of hundreds or even thousands of “potential individuals” would be formed. I submit that this is the proper use of the term “potential life.” The gametes, while certainly alive individually as cells, really do represent potential life when viewed as precursors of a new individual. This potentiality does not consist in their single cell status, but in their being haploid rather than diploid. Once two gametes join, that potentiality has been reduced to act, and life is not potential, but actual. There is thus no ambiguity or inconsistency in defining “life” as beginning at conception when a unique individual starts to grow and develop.

Secondly, I noted in his diagram of the brain activity of the fetus and the dying individual that the lines have opposite slopes. This is not a trivial or unimportant distinction. When the dying person’s brain reaches that level of function, what it means to call it “dead” is that a point of no return has been passed. If no intervention is made, and often even if vigorous intervention is made, the body in question will soon be “dead” in the most unmistakable fashion, with bodily functions halted and the body sinking into decay. This is emphatically not the case for the fetus. Below this point or above it, the

fetus continues one steady process of increasing function, orchestrated by its unique genetic composition. Unless some outside force intervenes, the fetus can be expected to be born and assume the state which most people recognize as “being a person.” Aside from a theoretical construct, there is no event at this point that distinguishes the living from the dead. Below this point it may not have the requisite brain activity, but, unless a catastrophe occurs, it predictably will. And this biological engagement in growth and development is one of the major elements which we point to in calling any organism “alive.” It seems specious to deny to a human fetus what we would unhesitatingly predicate of a fetal pig (before being preserved in formaldehyde, of course!).

Finally, I applaud Dr. Mazzarelli’s concluding clause. Indeed, this is the crux of the matter. Once “an entity,” at least a human entity, meets the definition of life, it should be accorded the protection from deliberate illegal harm that all human societies accord to their own members. Past societies could not know that an entity was growing and developing so competently in the womb at these early stages. We cannot plead such ignorance. And what reason, other than a desire to have the liberty to do what are perceived as useful, if potentially or certainly harmful, things to them would provoke a society to define its offspring as “dead” for the first and most wonderful twenty weeks of development?

Ellen H. Gryniewicz, M.D.  
(ΑΩΑ, *University of Michigan*, 1971)  
*Ann Arbor, Michigan*

### More on “Eurekapenia”

I was pleased to see the thoughtful piece on “Eurekapenia” in the Spring 2003 (pp. 24–26) of *The Pharos*. I am in very strong agreement with you that the lack of a sense of discovery for today’s students and residents, replaced by a sense of relatively superficial management of problems without discerning their causes, can be somewhat intellec-

tually inhibiting and stultifying. I look back with glee and affection on the search for red snappers and granular casts in my own training.

However, I am not sure that the provision of these kinds of tools to residents, tools that they will never have a chance to use outside of the residency setting, is the best use of resources. Although it is attractive to provide them with links to the intellectual past by giving them opportunities to read blood smears or Gram stains, I am not sure that that is the best way to prepare them for the future, or to train them to make future discoveries on their own. I wonder about training them in the use of techniques for intellectual structures that will be useful for them in the later careers. For instance, in today’s diagnostic world, there is progressively less use for Gram stains and much more for molecular diagnostic approaches. Perhaps the time on rounds could be spent reminding people how PCR is done or showing them how the data from PCR reactions is translated into the determination of whether an organism is a suspected pathogen. Flow cytometry is another example. These techniques are the critical diagnostic studies for the next generation. Techniques that residents are unlikely to learn to do well, because they will never do a significant volume, and that they probably cannot legally decipher on their own, even in the hospital setting, conspires to make the use of the older generation of bedside diagnostic tools somewhat obsolete.

The more difficult question is how to teach them the newer ones, once one decides what it is that ought to be taught. I still believe that the didactic experience of good ward rounds is well worth the effort. Smears and stains are very exciting in that context if someone who knows what they are looking at is there to explain them. So I would suggest an investment in projection screens or television cameras that would allow you to show to the group the slide under discussion. You rightly point out that as

the process of patient care becomes more and more one of interpreting data that comes in from other sources and consultants, the innate thrill of seeing things oneself for the first time becomes more elusive. However, I suspect that the way to get around that is to teach residents how to connect the dots themselves, rather than how to draw them in the first place.

Thank you for such a thoughtful and provocative piece.

Steven M. Holland, M.D.  
(ΑΩΑ, *Johns Hopkins University*, 1983)  
*Bethesda, Maryland*

I don’t know how to categorize this letter: manuscript, editorial, or just informational. At any rate, I really enjoyed “Eurekapenia” (Spring 2003, pp. 24–26). Dr. Hellmann stimulated wonderful memories for me, as I’m sure he did for many others. What physician wouldn’t enjoy thinking back on some of their finest diagnostic successes? It’s very satisfying to score a triumph now and then, particularly if that “triumph” means therapeutic benefit to the patient. It makes the hard work of medical training certainly worth it, and in a flash. Perhaps it’s mostly ego. Nonetheless it’s a victory, a lasting one.

For me the satisfaction came from making a diagnosis from only the history (best), physical exam (great), or a confirmatory lab test I could perform (good). My examples are as follows:

1. As an intern assigned to the neurology service I was the first to examine a boy sent from a hundred miles away because of frequent convulsions. At that time I was still developing my routine work-up physical exam and this included a Chvostek test. I tapped the boy’s facial nerve and obtained a tremendous facial contraction! After several more taps in confirmation, I performed a Trousseau test on his arm and the response was a vigorous contraction. I performed a urine calcium test and it was 4+. Other laboratory studies confirmed the diagnosis of hypoparathyroidism.

2. As a resident I was asked by an attending to see a middle-aged suburban homemaker who complained of feeling tired. I don't recall any of the details of my work up until it came to examining her chest. Upon touching the skin over her sternum—eureka!—it felt just like that of the several myxedematous patients I had seen within the previous two years. With further questioning and lab studies this diagnosis was confirmed.

3. Some years ago my wife and children went picnicking with an in-law who said that he perspired so heavily that he dare not sit in upholstered chairs. His responses to a few questions and a brief "public" physical exam led to classic hyperthyroidism, cured by subsequent thyroidectomy.

4. A concerned student nurse was referred to our clinic because of persistent microscopic hematuria with red blood cell casts, diagnosed as glomerulonephritis. In my routine family history I asked about any known renal disease and she recalled that someone from Utah had come to her home in Idaho and taken urine samples from her relatives. Upon subsequently contacting the Utah group that had reported a large kindred with familial nephritis (Alport's syndrome), I learned that her family was included in the group. Affected females had a benign prognosis, hence I had very good news for her.

5. I've had some embarrassing losses, too! The most remarkable occurred in my navy days, while at anchor offshore. A seaman who had been on

deck came to sick bay complaining of sudden pain in his eye, as if something were in it. (It was windy on deck.) I put in a drop of fluorescein and the result was a huge stain on his cornea. Horrible! A huge corneal abrasion! This was not for me, a general internist at the time. Fortunately, there was a (permanent) hospital ship at the dock and the seaman and I promptly motored over to it and its (thankfully) ophthalmologist. Eureka! The latter promptly removed a piece of cellophane (from a cigarette wrapper) and the seaman and I (chastened) returned to our ship.

Roy H. Maffly, M.D.  
(ΑΩΑ, University of California, San Francisco, 1952)  
Palo Alto, California

## Instructions for *Pharos* authors

We welcome material that addresses scholarly and nontechnical topics in medicine and public health such as history, biography, health services research, ethics, education, and social issues. Poetry is welcome, as well as photograph/poetry combinations. Photography and art may also be submitted. Fiction is not accepted. All submissions are subject to editorial board review. Contributors need not be members of Alpha Omega Alpha. Papers by medical students and residents are particularly welcome.

Submissions must meet the following criteria:

1. Submissions may not have been published elsewhere or be under review by another journal.

2. Essays should have a maximum of 15 pages (approximately 5000 words), and be submitted in 12-point type, double-spaced, with one-inch margins. They should be accompanied by a covering letter, a 150-word abstract, and a title page with the word count (or page count), return address, and e-mail address. Papers exceeding the page count noted will be returned to the author. References should not exceed 20 unique items (see below).

3. Poems or photograph/poetry combinations should be in 12-point type, with one-inch margins, with the author's name, address, and e-mail address on the first page.

4. Send your submissions to Edward D. Harris, Jr. M.D., Editor of *The Pharos*, 525 Middle-

field Road, Suite 130, Menlo Park, California 94025. You may also e-mail them to: postmaster@alphaomegaalpha.org.

5. After peer review, comments on the manuscript will be sent to the author along with an editorial decision. Every attempt is made to complete preliminary reviews within six weeks.

6. The editors of *The Pharos* will edit all manuscripts that are accepted for publication for style, usage, relevance, felicity, and grace of expression, and may provide appropriate illustrative material. Authors should not purchase illustrative material because the editors cannot guarantee that it will be used.

7. In accordance with revised copyright laws, each contributor will need to sign an Author's Agreement, which will be sent with the edited galley. Information on copyright ownership and re-publication of articles is detailed in the Author's Agreement.

### Reference information

Authors are responsible for the accuracy of citations and quotations in their papers. Once a manuscript has been accepted for publication, therefore, the author will be required to provide photocopies of all direct quotations from the primary source material, indicating page numbers. In addition, the editors will require photocopies of all references: the title page and copyright pages of all books cited, the first and last pages of book chapters cited, and the first and last pages of journal articles cited, as well as

the Table of Contents of the particular issue of the journal in which the cited article appeared. The foregoing items will be used to verify the accuracy of the quotations in the text and the references cited, and to correct any errors or omissions.

References should be double-spaced, numbered consecutively in the text, and cited at the end in the following standard form:

Journal—Zilm DH, Sellers EM, MacLeod SM, Degani N. Propranolol effect on tremor in alcoholic withdrawal. *Ann Intern Med* 1975; 83: 234–36.

Book—Harris ED Jr. *Rheumatoid Arthritis*. Philadelphia: WB Saunders; 1997.

Book chapter—Pelligrini CA. Postoperative Complications. In: Way LW, editor. *Current Surgical Diagnosis and Treatment*, Ninth Edition. Norwalk (CT): Appleton & Lange; 1991: pp 25–41.

Each reference should be listed in the bibliography only once, with multiple uses of a single reference citing the same bibliography reference number. Examples are available at our web site: [www.alphaomegaalpha.org](http://www.alphaomegaalpha.org).

Citation of web sites as references is discouraged unless a site is the single source of the information in question or has official or academic credentials. Examples of such sites are official government web pages such as that of the National Institutes of Health. Encyclopedia sites such as [britannica.com](http://britannica.com) are not primary references.